



8. On August 6, 2015, UHC amended the Filing and replaced the Schedule with an amended form. The amended Schedule is the subject of this Order.
9. Brackets ( [ ... ] ) within a policy form reviewed by the Division indicate that the language within the brackets may be included or excluded from the policy form, or the brackets may indicate a numeric range.
10. On page 1 of the Schedule under the section titled Selecting a Network Primary Physician, the form states in relevant part:

You must select a Network Primary Physician in order to obtain Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*. A Network Primary Physician will be able to coordinate all Covered Health Services and make referrals for services from Network Physicians. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Physician for that child. If you do not select a Network Primary Physician, one will be assigned.

(Emphasis in original).

11. On page 2 of the Schedule under the section titled Accessing Benefits, the form states in relevant part:

A higher level of Network Benefits is provided when Covered Health Services are provided by or referred by your Primary Physician. If care from another Network Physician is needed, your Primary Physician will provide you with a referral. The referral must be received before the services are rendered. If you see a Network Physician without a referral from your Primary Physician, you will receive a lower level of Network Benefits, regardless of the place of services. This lower level of Benefits will apply to all related services and facility charges received without the required referral.

12. Throughout the Schedule for various coverages, the form provides bracketed language that explains to the insured that coverage with a referral will be provided at a coinsurance rate of “[50-100%] while coverage without a referral will be provided at a coinsurance rate of “[50-100%].”
13. Due to the bracketing within the Schedule and the absence of a filing memorandum disclosing the same, it is impossible for the Department to determine what coinsurance penalty UHC will assign for coverage sought without first obtaining a referral.

14. Nowhere within the Filing does UHC disclose to the Department the actual coinsurance difference between in-network coverage received with a referral and in-network coverage received without a referral.

### CONCLUSIONS OF LAW

Pursuant to §376.405, the Director shall approve only those policy forms that are in compliance with Missouri insurance laws, and “which contain such words, phraseology, conditions, and provisions which are specific, certain and unambiguous and reasonably adequate to meet needed requirements for the protection of those insured.” The Director may disapprove a form filed with the Department, and in doing so must state the reasons for the disapproval in writing. Section 376.405.

Senate Bill 262 was enacted in 2013. Within its provisions was an amendment to §376.426 that permitted insurers to offer and sell Exclusive Provider Organization health plans, which are commonly referred to as EPOs.

Notwithstanding any other provision of law to the contrary, a health carrier, as defined in section 376.1350, may offer a health benefit plan that is a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services, as defined in section 376.1350, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in clear, conspicuous, and understandable language in the enrollment application and in the policy form. Whenever a health carrier offers a health benefit plan pursuant to this subdivision to a group contract holder as an exclusive or full replacement health benefit plan the health carrier shall offer at least one additional health benefit plan option that includes an out-of-network benefit. The decision to accept or reject the offer of the option of a health benefit plan that includes an out-of-network benefit shall be made by the enrollee and not the group contract holder[.]

Section 376.426(19), RSMo (Supp. 2013). This provision allows an insurer to offer a product with an exclusive network of providers through a managed care plan. Section 376.1350 defines a managed care plan as “a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier[.]” Section 376.1350(24), RSMo (Supp. 2013). With some noted exceptions, an insured that purchases such a product must seek medical attention within that network to receive coverage under the plan.

On August 6, 2015, UHC filed an EPO-type product with the Department for review and approval. Based upon the form's language, UHC is not only restricting its out-of-network coverage (as permitted pursuant to §§376.426 and 376.1350), but also is restricting the insured's access to providers within the exclusive provider network through the use of Primary Care Physicians (“PCPs” or “gatekeepers”). The Schedule

restricts access to the provider network by penalizing, with a higher co-insurance rate, insureds who use a network physician without obtaining a referral from a PCP or gatekeeper. Restricting an insured's access to network physicians by requiring a referral from a gatekeeper violates the Unfair Trade Practices Act.

Under the Act, unfair discrimination includes:

not permitting the insured full freedom of choice in the selection of any duly licensed physician, surgeon, optometrist, chiropractor, dentist, psychologist, pharmacist, pharmacy, or podiatrist; except that the terms of this paragraph shall not apply to health maintenance organizations licensed pursuant to chapter 354[.]

Section 375.936(11)(b), RSMo 2000. By requiring a gatekeeper, UHC is limiting insureds' full freedom of choice in the selection of their in-network care provider. This limitation is prohibited by the Unfair Trade Practices Act.

Missouri law does include provisions that allow for gatekeeper arrangements like those described within the Schedule, but those provisions are only found in Missouri's Health Maintenance Organization ("HMO") laws, §§354.400-.636, which are not applicable to insurers operating under chapter 376. Under the HMO laws, a PCP is defined as:

a participating health care professional designated by the health carrier to supervise, coordinate or provide initial care or continuing care to an enrollee, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the enrollee.

Section 354.600(11), RSMo (Supp. 2013). Under the HMO laws, a gatekeeper group plan is defined as "a plan in which the enrollee is required to obtain a referral from a primary care professional in order to access specialty care[.]" Section 354.618.2(2), RSMo 2000.

According to the Schedule's language, an insured's full freedom of choice is limited by the use of gatekeepers. Within the Schedule (and in HMO products not at issue here), PCPs or gatekeepers are generally the primary touch point for insureds to gain access to the provider network; they manage and coordinate care through the use of referrals to other in-network physicians. Under the Schedule, insureds would not have the "full freedom of choice" because they would be penalized through the reduction of benefits if the insured does not first get a referral from the gatekeeper. Such restrictions within the Schedule violate §375.936(11)(b) because the insured's choice of provider has been limited through the use of the gatekeeper.

By utilizing gatekeepers in its EPO product, UHC has attempted to emulate restrictions that are found in products offered by HMOs, which are organized under §§354.400-.636 and exempted from the full freedom of choice requirements of §375.936(11)(b). United's

Schedule is not an HMO product and cannot be one because UHC is not an HMO. Hence, the Schedule is subject to §375.936(11)(b). Additionally, while UHC wishes to utilize HMO-style restrictions in the Schedule, its Schedule – which is an EPO-type product – is not required to and does not provide the consumer protections afforded within Missouri’s HMO laws.

While an HMO is permitted to utilize a PCP, both explicitly within Chapter 354 and implicitly through its exception from full freedom of choice requirement, HMOs must comply with a myriad of statutory protections for their customers. Some examples of consumer protections that an HMO must provide include, but are not limited to:

- Ensuring that its network of providers is adequate and such must be submitted to the Department for review and approval, §354.603, RSMo (Supp. 2013);
- Ensuring that the consumer obtains a covered benefit at no greater cost than if the benefit was obtained from a participating provider in the event a network is inadequate for such benefit, §354.603.1(1);
- Requirements for contracts between the HMO and participating providers that provide for consumer protections, §354.606.2, RSMo (Supp. 2013);
- Allowances for up to 90 days continuation of treatment for consumers when the contract between the HMO and the provider is terminated, §354.612, RSMo 2000.

By contrast, an insurer offering an EPO-type product is not required to provide any of these protections. Rather, what an EPO product must do is provide for the full freedom of choice to its insureds within its exclusive provider network. This form fails to do so. By subjecting its insureds to an HMO-style gatekeeper, this policy violates §375.936(11)(b). As such, the Schedule does not comply with the laws of this state as required by §376.405.

By attempting to utilize specific restrictive elements of an HMO product without its required benefits and protections, the Schedule is not reasonably adequate to meet the needed requirements for the protection of Missouri consumers as required by §376.405.

After review and consideration of the Schedule included in the UHC Filing, the company has failed to demonstrate its compliance with Missouri law as enumerated herein. While there may be additional reasons as to why this Schedule does not comply with Missouri’s insurance laws, the reasons stated herein are sufficient to disapprove the form. Each reason stated herein for disapproval of the Schedule is a separate and sufficient cause to disapprove such form.

UnitedHealthcare’s Schedule does not comply with Missouri law. As such, said form is not in the public interest.

This Order is in the public interest.

**IT IS THEREFORE ORDERED** that Form SBN.16.CHTNVB.I.11.MO.KA is hereby **DISAPPROVED**. UnitedHealthcare Insurance Company is hereby prohibited from delivering or issuing for delivery any policies of group health insurance utilizing said forms.

**SO ORDERED, SIGNED AND OFFICIAL SEAL AFFIXED THIS** 2<sup>ND</sup> day of September, 2015.



  
**JOHN M. HUFF**  
**DIRECTOR**

**NOTICE**

**TO: UnitedHealthcare Insurance Company and any unnamed persons aggrieved by this Order:**

You may request a hearing on the disapproval of these forms. You may do so by filing a pleading with the Director of the Department of Insurance, Financial Institutions and Professional Registration, P.O. Box 690, Jefferson City, MO 65102, within 30 days after the mailing of this notice pursuant to 20 CSR 800-1.030.

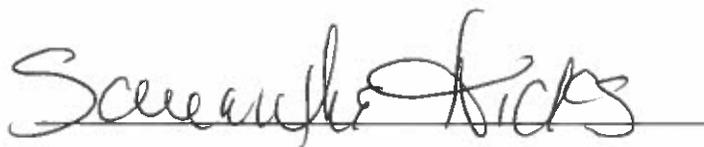
**CERTIFICATE OF SERVICE**

I hereby certify that on this 3<sup>rd</sup> day of September, 2015, a copy of the foregoing Order and Notice was

Served via certified mail addressed to:

Jeffrey D. Alter  
President  
UnitedHealthcare Insurance Company  
48 Monroe Turnpike  
Trumbull, CT 06611

Rebecca Fields  
Regulatory Affairs Analyst  
UnitedHealthcare Insurance Company  
7440 Woodland Drive  
Indianapolis, IN 46278

A handwritten signature in cursive script, appearing to read "Rebecca Fields", written over a horizontal line.